

FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1268
238
Registrar's No. _____

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH: Jackson
(a) County _____
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 25 years years, months or days)

3. (a) PRINT FULL NAME EDITH CARRELL
(b) If veteran, No name war _____ 3. (c) Social Security No. No

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, 2 divorced Widow
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive 0 years
7. Birth date of deceased July 27th 1869 (Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 15 If less than one day hr. _____ min. _____

9. Birthplace Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER { 12. Name Al Spore
13. Birthplace Ohio (City, town, or county) (State or foreign country)
14. Maiden name Clara Clark
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address K.C. General Hospital

17. (a) Burial (b) Date thereof 1-16-41 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Edm. A. Longmire
(b) Address 112 E. Main Street

19. (a) Jan 16, 1941 (b) M. M. Crowe (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 48
(a) State Missouri (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 931 East 11th St. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 11th
year 1941 hour 11 minute 20 P.M.

21. I hereby certify that I attended the deceased from 1-10-1941, 19____, to 1-11-1941, 19____;
that I last saw her alive on 1-11-1941, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia, cause undetermined

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work (Specify type of place) (a) Means of injury _____
23. Signature Dr. R. R. Thorne (M. D. or other)
Address Med. Dir. K.C. General Hospital Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Wm A. Lohmeyer

Licensed Embalmer No.

3089

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.